Current Patient Information 2016

Please complete the following so we may update our records. Thank you!

File ID# _____ Today's Date: _____

PATIENT INFORMATION *SEE SECTION BELOW TO INCLUDE DEPENDENTS

Date of Birth: _____

_____
first name middle last

_____
cell phone home phone work phone

_____
e-mail address (for appointment reminders)

ADDRESS ❑ *address is same as 2015 or complete below*

_____
street address city state zip

Status: ❑ single ❑ married ❑ divorced ❑ partner ❑ widow

_____
Emergency Contact phone relationship

HIPAA PRIVACY:

By signing here you are authorizing you have read and understand your HIPAA rights. Full HIPAA Privacy Disclosure is available at the front desk or online at HeartlandWellnessCenter.com.

HIPAA Signature _____

COMMUNICATIONS: ❑YES ❑NO

I authorize Heartland Chiropractic and Wellness Center to leave/send detailed voice mail and/or email messages regarding my appointments, insurance, billing, flexible pending reports, patient communications, including patient care recommendations, etc. with the contact information I provided above.

_____**Please Initial** you have read the above statement and agree to communications.

AUTHORIZED PARTIES:

Who do you authorize HCWC to provide your private healthcare information regarding your appointment, payments, insurance information, etc.

parent _____ DOB_____

spouse/partner _____ DOB_____

doctor_____

other_____ DOB_____

AUTHORIZED DEPENDENT(S):

related to the contact and insurance information above.

Patient, Parent, Guardian or Personal Representative of the following Dependent(s) I authorize that I understand their HIPAA Rights and they are related to the Insurance Information provided on this form and release information as described under the Assignment and Release segment under the Insurance section of this form.

Name_____D.O.B._____

Name_____ D.O.B._____

Name_____D.O.B._____

Name_____D.O.B._____

For office use only

Same Insurance New Insurance New contact info

Notes:

PAYMENT OPTIONS:

How would you like us to process your visit(s) for your chiropractic services?

☐ **Time of Service** I would like to utilize Heartland Chiropractic's cash plan. ***If you checked this box your form is complete.***

☐ **Health Insurance** File my chiropractic visits to my health insurance as noted in the Insurance Section of this form.

INSURANCE:

☐ **My policy is the same as my last visit.** I am aware of my current chiropractic benefits. Please process through insurance.

☐ **I have new insurance/changes to my insurance.** I am aware of my current chiropractic benefits. Please process through insurance.

☐ I don't know my chiropractic benefits. **Please INITIAL _____ you have read the following section.**

I understand it is your office policy that I pay the Time of Service fee for today's visit to ensure I receive my chiropractic services at the lowest rate possible.

I understand that all visits/payments will be processed under the terms of Time of Service until I notify Heartland Chiropractic by phone, email or in person that I would like to file my chiropractic visits through insurance.

I believe my health insurance policy will cover chiropractic care through Heartland Chiropractic and I agree to contact your office by 12:00pm the following business day with my insurance policy and benefit information so HCWC may file the insurance claim for today's visit and future visits.

If we do not hear from you we will assume that you would like to pay for your visit(s) under the terms of our Time of Service Plan. Initial here I have read the above information in this section

INSURANCE INFORMATION:

Member ID# _____

Insurance Company: ❑BC/BS (PPO) ❑Medicare ❑ Coventry ❑ United Health Care ❑ Aetna ❑ Other

Policy Holder: ❑ self ❑ spouse/partner ❑ parent/guardian

_____
Policy Holder Name (if not self) DOB

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with above insurance company and assign directly to Drs. Valerie Skow and Juliet O'Donnell all my insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor/facility may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
SIGNATURE